

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39248**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 3063		Registrar's No. 2818	
1. PLACE OF DEATH a. COUNTY St. Louis,				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri, b. COUNTY St. Louis,			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton 5,				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton 5,			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Res: 6390 Forsyth Blv'd.,				d. STREET ADDRESS (If rural, give location) 6390 Forsyth Blv'd.,			
3. NAME OF DECEASED (Type or Print) EUGENE		a. (First) L.		c. (Last) TRASK.		4. DATE OF DEATH (Month) (Day) (Year) Nov 22, 1950.	
5. SEX Male.		6. COLOR OR RACE White.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed.		8. DATE OF BIRTH Dec. 18 1862	
9. AGE (In years last birthday) 87		10. UNDER 1 YEAR Months Days		11. BIRTHPLACE (State or foreign country) Augusta, Maine /		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Albion Trask		13b. MOTHER'S MAIDEN NAME Marissa M. Nettleton.		14. NAME OF HUSBAND OR WIFE Anna C. Trask.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS O.H. Mitchell; 6390 Forsyth Blvd.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 10 degenerative heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4243 INDEFINITE			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/13 , to 11-20 , 1950, that I last saw the deceased alive on 11-20 , 1950, and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Richard W. Maxwell M.D.				23b. ADDRESS 23720 Washington		23c. DATE SIGNED 11-22-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-25-1950		24c. NAME OF CEMETERY OR CREMATORY Lakewood Cem.		24d. LOCATION (City, town, or county) (State) Minneapolis, Minn.	
DATE REC'D BY LOCAL REG. 11-24-50		REGISTRAR'S SIGNATURE Herbert R. Donke M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons, 7233 Delmar Blv'd.,			

RWR (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

703800 - Room 415

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed Melvin L. Kemper

Signed.....
Student Embalmer

Licensed Embalmer No. 4052

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.